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EVALUATION OF THE MEDICAID FOSTER FAMILY CARE PILOT PROJECT

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Executive Summary

I. INTRODUCTION

The Massachusetts Medicaid Foster Family Care Pilot Project was designed in response to a need for an alternative to institutionalization for adults who are no longer able to live independently in the community. In 1978, the Massachusetts General Court passed Senate Bill 1564 establishing an adult foster care pilot project administered by the Medical Division of the Department of Public Welfare (DPW). The purpose of the foster family care pilot project was to provide room, board and personal care services in a family-like setting to a maximum of two elderly or disabled clients. The program's services are targeted to adults who would otherwise require Level III or Level II nursing home care and may require supervision on a 24 hour basis. Five sponsor agencies participated in the pilot project.

An evaluation of the Family Care Pilot Project was conducted by the Office of Research and Evaluation of the Department of Public Welfare during the pilot project year (February 1979-February 1980). The evaluation included program, outcome and cost components. Data were collected from sponsor agencies, monthly statistical reports, quarterly reports and final narrative reports as well as from participant and foster caretaker questionnaires.

II. EVALUATION RESULTS

A. Overview of Results

Overall, the results of the evaluation of the Foster Family Care Pilot Project indicate that foster care can be an effective alternative to institutionalization for disabled adults. The Massachusetts General Hospital Foster Care Project provides a clear picture of a functioning foster family care agency which is in full operation and which provides excellent support services to participants and family caretakers. Although participant placement rates were low for the project as a whole, the success of the Massachusetts General Hospital program suggests that foster family care can be a positive cost effective program for preventing the institutionalization of certain disabled adults.*

The following are highlights of the program's strengths identified by the evaluation:

1. Overall, sponsor agencies complied with contractual obligations set forth by the Department of Public Welfare, thus assuring that adequate supervision and support mechanisms were developed before participants were placed in foster care.

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* Because of the long "start-up" time required for this program, placement rates during the 12 month evaluation period were inappropriate for determining the success of adult foster family care. Therefore, the Massachusetts General Hospital Program, which began early in 1978 and which benefited from private foundation support, provides the best indication of a successful foster care program.

2. Overall, both participants and foster families expressed satisfaction with the foster family care program. Participants generally found family care to be strongly preferable to nursing home placement while family caretakers found the task of caring for disabled participants to be manageable and satisfying. Caretakers were particularly resourceful in developing informal short-term respite arrangements.

3. The projected rate for foster family care was found to be competitive with rates for Level III ICF care and with other adult foster care programs.

The following is a summary of major weaknesses identified in the evaluation:

1. The major weakness in the pilot program was the inability of most of the sponsor agencies to place adequate numbers of participants into foster family care within the 12 month start-up period.

2. The "lag time" required for Medicaid billing sometimes put a strain on sponsor agency budgets.

B. Results of Program, Outcome and Cost Evaluation

The following are summaries of the three evaluation components:

1. Program Evaluation

Overall, sponsor agencies fulfilled the contractual agreements developed by the Department of Public Welfare adequately. However, start-up time for program development was very slow. Out of a total of 732 potential foster care participants referred to the program during the pilot year, just 17% (123) were deemed eligible by program staff and only 7% (48) were placed with foster families. Similarly, out of 341 potential foster families referred to the program, just 20% (69) were considered appropriate for the program and only 10% (35) eventually participated in the program.

Because of the vulnerable condition of the participants, sponsors found it impossible to make placements until back-up services had been sufficiently developed. Massachusetts General Hospital which benefited from an earlier start-up date and supplemental funds from private sources, demonstrated that the foster family care program can be successful for participants and families once the initial start-up period had passed.

2. Outcome Evaluation

The demographic characteristics of participants and caretakers were similar. The typical participant was a white (95%) female, age 60 or over (79%) whose educational level is high school graduate or less (85%). The typical caretaker was a white (82%) female (94%) whose average age was 49 and who had a high school education or less (85%).

Overall, participants and family caretakers were satisfied with their foster care arrangements and with supervision and support from the sponsor agencies. Most of the participants (89%) and family caretakers (91%) found the program to be "very satisfying" or "satisfying" for them. Participants found foster family care to be a positive alternative to nursing home placement while caretakers generally found the care of the participants to be manageable and enjoyable. Participants appeared to have been integrated into foster family activities and plans while generally continuing with at least some aspects of their former interests and relationships. Caretakers had dealt with the issue of short-term respite care informally, rather than relying heavily on the sponsor agencies. The results of the outcome evaluation, then, indicate that foster family care is a positive and successful alternative to institutionalization for those participants and families who were involved in the program.

3. Cost Evaluation *

Overall, the costs of the Medicaid Foster Family Care Pilot Project, while reflecting the growing costs of long-term care services, appear to be competitive with alternative types of care provided within institutions as well as in the community. The projected per diem rate of $17.80 places foster family care costs lower than Level III ICF costs ($23.00-$30.00 per day) and slightly higher than Level IV rest home costs ($15.00 per day), which is appropriate given the level of care provided. Similarly, considering the extent of participant care required in the foster family care program and the stringent regulations requiring a maximum of 2 participants per family, the projected rate of foster family is competitive with rates of other adult foster care programs. The $17.80 projected rate falls well below the per diem rate paid by the Department of Mental Health ($29.58-$49.08) for specialized foster care.

While additional health maintenance costs appear to be high, $3,704.48 per participant per year, the figures included in this study are based on a limited sample and may not be reflective of overall health maintenance costs for foster care participants. In addition, comparisons with health maintenance costs, Level III populations, and community based adults living with families may show that these rates are not unusual for the needs of the population being served.

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*Actual program and administrative costs were not included in this report. A projected per diem rate of $17.80, which reflects cost estimates for the program operating with 20 clients in placements, was used as a basis of comparison for purposes of this report. This rate was suggested in a memo written by Richard Hill, consultant to the Commissioner of the Rate Setting Commission in October, 1979.

C. Recommendations

Major recommendations included the following:

1. The Department of Public Welfare should continue to fund only those sponsor agencies which can build their participant census to a minimum of 20 within 18 months of operation.

2. The Department should develop an RFP process for attracting and selecting new sponsor agencies.

3. Discussion with the Department of Public Health regarding the interpretation of the statute as it applies to this program should continue so that the maximum number of participants residing in one home can be expanded from 2 to 3.

4. Systematic, ongoing training should be developed by the Department for family caretakers using Title XX training modeled after the Foster Parent Training Program.

5. Each sponsor agency should develop several short-term respite care homes in each geographic area to provide ongoing respite as well as emegency back-up to foster family care.

6. The development of a uniform participant assessment tool should continue by the DPW Medical Division to assure statewide consistency in the level of disability of participants placed into foster care.

7. Additional health maintenance services, such as adult day health and occupational and physical therapy services, should be carefully monitored and limited for foster family care participants.

TABLE OF CONTENTS

		Page
	EXECUTIVE SUMMARY	i-v
I.	INTRODUCTION	1
	A. Background	1
	B. Purpose of the Foster Family Care Pilot Project	1
	C. Program Description	2
	D. Scope of the Evaluation	2
II.	RESEARCH DESIGN	3
	A. Sources of Data	3
	B. Response Rates	4
	C. Analysis Procedure	4
III.	EVALUATION RESULTS	5
	A. Program Evaluation	5
	1. Overview	5
	2. Sponsor Compliance with Provider Agreement	6
	3. Numbers of Clients and Families Served	8
	4. Major Difficulties Encountered by Sponsor Agencies	9
	B. Outcome Evaluation	10
	1. Overview	10
	2. Description of Participants Placed in Family Care	10
	3. Description and Responses of Family Caretakers	13
	C. Cost Study	16
	1. Overview	16
	2. Assessment of Per Diem Costs	17
	3. Comparison of Projected Per Diem Rate with Other Medicaid Services and Other Adult Foster Care Programs	18
	4. Additional Health Maintenance and Service Costs	20
	5. Assessment of Average SSI Costs Per Participant	22
IV.	CONCLUSIONS AND RECOMMENDATIONS	23-25
V.	TABLES	26-28
VI.	APPENDICES	

I. INTRODUCTION

A. Background

The Massachusetts Medicaid Foster Family Care Pilot Project was designed in response to a need for an alternative to institutionalization for adults who are no longer able to live independently in the community. In 1978, the Massachusetts General Court passed Senate Bill 1564 establishing an adult foster care pilot project administered by the Medical Division of the Department of Public Welfare (DPW). Five sponsor agencies were contracted to provide direct administration of the program in designated geographic areas. During 1979, the Department of Elder Affairs (DEA) provided start-up administrative funds as part of its demonstration grants project under Chapter 367. The following sponsor agencies were selected to participate in the pilot project:

Arlington Council on Aging

Cape Cod Hospital

Lowell Visiting Nurse Association

Massachusetts General Hospital

Elder Home Care Corporation of Southern Worcester County

In November, 1979, Arlington Council on Aging withdrew from the program. Massachusetts General Hospital expanded its program to include the Arlington caseload. As of May 1980, the Board of Directors of the Lowell Visiting Nursing Association has informed DPW that they will not be renewing their contract to provide foster family care services. Other agencies in the Merrimack Valley have expressed interest in foster family care and are working with DPW to continue such services.

B. Purpose of the Foster Family Care Pilot Project

The purpose of the foster family care pilot project was to provide room,board and personal care services in a family-like setting to a maximum of two elderly or disabled clients. The program, designed to serve adults requiring Level III and selected Level II care, uses the following definition of eligibility:

> any individual who, due to medical, physical or psychological problems cannot live independently in the community, who may require 24 hour supervision and who has no family or home of his/her own adequate to meet his/her needs. Such individuals may include:
>
> - individuals who currently reside in the community or are hospitalized and are at high risk of requiring nursing home placement.
>
> - patients discharged from nursing homes who would benefit from living with a foster family.
>
> - chronically disabled individuals who cannot be left alone without supervision.*

*"Appendix A - Program Description for Pilot Program of Adult Foster Care" Dept. of Public Welfare Medical Division (1/79)

C. Program Description

The Foster Family Care Project provided foster family placement for elderly persons and other adults who were medically eligible for the program. Each of the 5 sponsor agencies conducted outreach activities for project participants and family caretakers. In addition, the sponsor agencies were responsible for the following: 1) matching eligible participants with appropriate foster family caretakers; 2) providing ongoing training, supervision and medical back-up to foster caretakers and participants; 3) developing linkages with other community services; and 4) providing 24 hour emergency telephone support.

The program was funded as a pilot project from January 1, 1979 through December 31, 1979. During the start-up year, sponsor agencies received funding, developed administrative procedures and assessment tools, and began placing participants in foster family care.

D. Scope of the Evaluation

Massachusetts Senate Bill 1564, which establishes an adult foster care pilot program in the Department of Public Welfare, requires that "the Department shall, at the outset of the program, establish criteria to evaluate the program's cost effectiveness and life enhancement features compared to Level III long-term facilities and other alternative modes of care."

In the Spring of 1979, the Office of Research and Evaluation of the Department of Public Welfare developed an evaluation design which was reviewed by the Director of Alternatives to Longterm Care in the Medical Division and the Foster Family Care Advisory Committee. The evaluation included three major components: 1) a program evaluation which was designed to assess the extent to which the sponsor agencies fulfilled the program objectives and adhered to the contractual agreements set forth by the DPW; 2) an outcome evaluation which was designed to assess the participants' and family caretakers' responses to the program; and 3) a cost assessment, which compares a projected foster family program rate with rates of similar long-term care services and programs. This report does not include an analysis of actual administrative costs during the pilot project year.

II. RESEARCH DESIGN

A. Sources of Data

Data for the program evaluation were collected from the following sources: Sponsor Agencies' Monthly Statistical Reports; Quarterly Administrative Reports; and Final Narrative Reports. These instruments were completed by the project directors in each agency and mailed to the Department of Public Welfare, Medical Division. For the outcome evaluation, Participant and Foster Family Questionnaires were distributed by the sponsor agency staff to program participants and family caretakers between February 1 - 29, 1980. Cost data were also collected from the above instruments.

More specifically, the following instruments were developed for data collection:

1. Sponsor Agencies' Monthly Statistical Report (Appendix A)

   This instrument provided a monthly statistical record of sponsor agencies' activities including numbers of potential clients and families referred; demographic characteristics of participants; types and amounts of services provided to clients; and agencies referring clients to the program.

2. Sponsor Agencies' Quarterly Administrative Report (Appendix B)

   This instrument was completed quarterly and provided information concerning the extent to which sponsors fulfilled their responsibilities as set forth in the Provider Agreement. The report included: information on interagency agreements; outreach activities to families and hospitals; foster family caretaker training; and supervision.

3. Final Narrative Report (Appendix C)

   Project sponsors were asked to submit a written summary of the highlights and problems that emerged during the project year.

4. Participant Questionnaire (Appendix D)

   This instrument was administered to program participants during February, 1980 and included: demographic characteristics; financial information; daily activities in foster family care; and participant satisfaction with the program.

5. Foster Family Questionnaire (Appendix E)

This instrument was administered to the primary caretaker in each foster family during February, 1980 and included: demographic and employment background; previous related experience; daily activities as foster caretakers; respite care arrangements; satisfaction with foster care; and subjective functional assessment of the participant.

B. Response Rates

Of the 41 foster family care participants in placement during February, 1980, 93% (38) responded to the participant questionnaire. Of the 35 families participating in the program during February, 1980, 97% (34) responded to the questionnaire.

C. Analysis Procedure

Due to the small sample size (n = 38), statistical procedures were limited to computation of frequencies and percentages. Participant and family caretaker satisfaction were ranked on a five point scale where a score of "1" represented strong satisfaction and a score of "5" represented strong dissatisfaction. Participant functional levels and interpersonal skills were ranked on a three point scale where a score of "1" indicated that the participant usually needed assistance and a score of "3" indicated that the participant usually needed no assistance. Program service costs were computed and annualized from Sponsor Monthly Statistical Reports.

III. EVALUATION RESULTS

A. Program Evaluation

The objective of the program evaluation was to assess the sponsor agencies' overall ability to plan and implement the foster family care program within the guidelines developed by the Department of Public Welfare. This evaluation includes the following 4 sections: 1) an overview of the findings; 2) the extent to which sponsor agencies complied with the DPW Provider Agreement; 3) the number of clients and families served during the pilot project year; and 4) a discussion of the major difficulties encountered by the sponsor agencies.

1. Overview

Overall, sponsor agencies fulfilled the contractual agreements developed by the Department of Public Welfare adequately. However, start-up time for program development was very slow. Out of a total of 732 potential foster care participants referred to the program during the pilot year, just 17% (123) were deemed eligible by program staff and only 7% (48) were placed with foster families. Similarly, out of 341 potential foster families referred to the program, just 20% (69) were considered appropriate for the program and only 10% (35) eventually participated in the program.

Because of the vulnerable condition of the participants, sponsors found it impossible to make placements until back-up services had been sufficiently developed. Massachusetts General Hospital which benefited from an earlier start-up date and supplemental funds from private sources, demonstrated that the foster family care program can be successful for participants and families once the initial start-up period had passed.

It is noteworthy that Arlington Council on Aging, which withdrew from the project before the end of the first year, had fulfilled its contractual agreements thoroughly, according to an administrative evaluation of all sponsors conducted in October, 1979 by the DPW and DEA staffs. The low placement rates, then, indicate that a slow start-up does not appear to be the result of the sponsors' inabilities to develop the program components. More likely, low placement rates are reflective of the "newness" of the foster care concept; the initial low fee of $300 per month*, and the level of care required for adult participants.

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*The personal care fee for foster families was raised to $403 per month during the pilot year. DPW has been granted an IRS ruling that the amount of the $403 that the family is reimbursed for providing room and board and personal care services is non-taxable unless it exceeds actual expenses for providing those services.

2. Sponsor Compliance with Provider Agreement

An analysis of each sponsor's monthly and quarterly reports indicates that, overall, the agencies fulfilled their contractual obligations with the DPW adequately although start-up time was longer than anticipated. Because of the diversity of agency types as well as staffing and funding levels, there were variations in the way each program component developed among the agencies. Although the program was very slow to develop to the point where placements could be made, specific program components were implemented by sponsor agencies in accordance with contractual obligations. The following is a summary of sponsor agencies' activities in fulfillment of the Provider Agreement:

a. Interagency Agreements

Each sponsor agency was required to develop inter-agency agreements with local acute care hospitals and with local home health agencies. While two of the sponsor agencies, Cape Cod Hospital and Massachusetts General Hospital, had acute hospital back-up available within their own facilities, the other sponsors made interagency agreements with local hospitals to provide emergency medical back-up to participants. Similarly, 4 sponsors made agreements for home health support with local home health agencies while Lowell provided its own home health back-up.

b. Discharge Planning Procedures, Participant Assessment and Intake Forms

During the first 9 months of the program year, each sponsor developed and submitted to the DPW discharge planning procedures and participant assessment and intake forms which were approved by the Medical Division.

c. Foster Family Training

Each sponsor agency developed a training package for the foster family caretakers which included group as well as one-on-one training sessions. Usually a Social Worker or an RN provided the training which included patient transfer, checking blood pressure and vital signs, knowledge of community resources, etc. After an introductory group training, in-service training was continued for caretakers on an individual basis. The sponsor agencies found individual training to be most effective and discontinued group trainings after initial efforts.

d. Respite Care

In general, foster family caretakers were able to find their own respite care for participants through informal arrangements with relatives and neighbors. In addition, home health aides provided short-term respite to caretakers during the day. Sponsor agencies which were not associated with hospitals reported initial difficulty in identifying nursing homes, foster family emergency homes or hospital back-up for respite care. Overall, respite care was provided within the foster family care guidelines as developed by DPW.

e. Twenty-Four Hour Telephone Service

Twenty-four hour telephone service was made available to all families and participants; however, calls were rarely made after 5 PM on weekdays. The average number of calls made after hours by each sponsor during a three month period was 2.

f. Participant Medical Approval and Release Forms

Each agency reported that appropriate medical approval was regularly secured for each new participant. In addition, participants regularly signed liability waivers with foster families and the sponsor agency. Each sponsor also developed and utilized a "contract of agreement" signed between the foster family and the participant.

g. Efforts to Secure Outside Funding

While all agencies attempted to secure additional program funding during the project year, only 2 were successful. Elderly Services of Southern Worcester County received a Title III grant from the local Area Agency on Aging and

Massachusetts General Hospital had ongoing support from the United Way, Permanent Charities and Weber Charities. Massachusetts General Hospital made arrangements for all 5 agencies to use funds in a "revolving account" through Weber Charities which paid family caretakers during the interim period after placements were made but before Medicaid payments were received.

h. Outreach to Potential Families and Participants

All 5 sponsors conducted community outreach activities during the project year to recruit foster families and participants. Newspaper publicity, community speaking engagements, flyers, radio and television publicity, staff visits to senior centers,and letters to social services agencies were the most common outreach methods used.

i. Supervision

In general, all 5 sponsor agencies reported that they conducted the required visits to foster families after placement had been made. This was confirmed by foster caretakers answering the questionnaire. Supervision included 1 visit within three days after placement, 1 visit weekly during the first three months and ongoing monthly visits thereafter. When problems arose, visits were more frequent and occasionally were decreased after the first month when a stable placement had been made. Directors of the smaller agencies expressed concern that ongoing follow-up visits would be difficult to continue when participant census expanded beyond 10.

3. Numbers of Clients and Families Served (Table 1)

During the project year, a total of 732 potential clients were referred to the project. Less than one-third of these (30%) were interviewed after telephone screening. Just 17% (123) of the total number of clients referred were judged eligible by the professional staff. Finally 6% (44) of the 732 clients referred were placed with foster families during the year.

Similarly, from a total of 341 potential foster families identified, 39% (134) were interviewed after initial telephone screening, 20% (69) were judged eligible and just 11% (37) eventually participated in the program.

Clients were most often screened out of the program after referral for the following reasons: 1) clients were inappropriate for foster family care, being either too ill or too independent for placement; 2) no home was available to accommodate a wheelchair; and 3) clients' biological family preferred nursing home placement for the client. The following reasons were most often given for non-participation of referred foster families: 1) family preferred to work with elderly requiring less care; 2) insufficient supervision was available during the day; 3) financial remuneration was too low.

Clients were most often referred to foster care from hospitals (53%), followed by relatives and friends (14%), home care corporations (8%), and nursing homes (6%) (Table 3).

4. Major Difficulties Encountered by Sponsor Agencies

Sponsors reported that they encountered the following ongoing difficulties during the project year:

1. difficulty of attracting adequate numbers of suitable foster families;

2. difficulty of finding participants requiring Level III care;

3. delay in claim processing for reimbursements of foster families;

4. difficulty of developing emergency and respite residential back-up;

5. difficulty dealing with participants' biological families who were often reluctant to place a relative in foster family care; and

6. instability of participants' health status, requiring extensive staff time making alternative arrangements when crises occurred.

B. Outcome Evaluation

The objective of the outcome evaluation is to determine the extent to which the participants and foster family caretakers adjusted to the family care program. This evaluation includes the following sections: (1) Overview of the findings; 2) Description and Responses of the Participants Placed in Family Care; and 3) Description and Responses of Family Caretakers.

1. Overview

The demographic characteristics of participants and caretakers were similar. The typical participant was a white (95%) female (79%), age 60 or over whose educational level was high school graduate or less. Similarly, the foster caretaker was a white (82%) woman (94%), whose average age was 49, and whose educational level was high school graduate or less (85%).

Overall, participants and family caretakers were satisfied with their foster care arrangements and with supervision and support from the sponsor agencies. Most of the participants (89%) and female caretakers (91%) found the program to be "very satisfying" or "satisfying" for them. Participants found foster family care to be a very positive alternative to nursing home placement while caretakers generally found the care of the participants to be manageable and enjoyable. Participants appeared to have been integrated into foster family activities and plans while generally continuing with at least some aspects of their former interests and relationships. Caretakers had dealt with the issue of short-term respite care informally, rather than relying heavily on the sponsor agencies. The results of the outcome evaluation, then, indicate that foster family care is a positive and successful alternative to institutionalization for those participants and families who were involved in the program.

2. Description of Participants Placed in Family Care

A. Demographic Characteristics of Participants (Table 3)

Overall, the typical foster care participant responding to the questionnaire was a white female, age 60 or over whose educational level was high school graduate or less. Nearly two-thirds of the participants (61%) were Roman Catholic while one-third (34%) were Protestant. While over half (58%) of the respondents were widowed or divorced, a large minority, 39%, were never married, and only 3% were married at the time of foster care placement.

B. Financial Status

In general, foster care participants responding to the survey relied on Social Security (68%) and over half (55%) reported that they received SSI. Of those reporting the amount of the SSI check, the mean amount was $142 per month with a range of $12-$337 dollars per month. Most respondents received $78.00 per month spending money. While most of these (71%) found $78.00 to be adequate, 16% felt that this was an insufficient amount because they were not able to save money or needed more for transportation and clothes. Two-thirds of the respondents had medical insurance other than Medicaid, usually Medicare.

C. Experience in Adult Foster Care

Length of respondents' stay in foster homes ranged from 1-14 months, with a mean of 5 months. About one-fourth (24%) had lived in foster care homes prior to moving in with their current foster families. Nearly half (47%) had been hospitalized immediately prior to moving in with a foster family, while 37% had been in a long-term care facility, 11% had been living alone in the community, and 5% had lived with relatives or friends immediately prior to foster home placement.

More than half (58%) of the respondents saw or spoke with relatives and friends during the week while an additional 29% did so at least once a month. Children and siblings were most often in contact with participants. However, 11% reported that they "hardly ever or never" saw relatives or friends.

Only 37% of the respondents reported that they attend recreational activities outside of the foster home while 58% said that they did not. Of those who did participate in activities outside of the home, activities most frequently mentioned were shopping, church, senior citizen social activities and visits with relatives.

D. Contact with Sponsor Agency

Most (95%) of the respondents reported that they saw a staff worker from the sponsor agency at least once a month while one-third saw the worker at least once a week.

E. Overall Health

In general, respondents rated their own health as "very good or good" but acknowledged that their health had failed during the past 5 years. Medical conditions of participants varied and included diabetes, hypertension, fractured hip, post surgical convalescence, sight and hearing impairments, coronary disease and amputations.

F. Satisfaction with Foster Family Care (Table 6)

The overwhelming majority of respondents (90%) reported that they felt "very satisfied or usually satisfied" with their foster families. Only 8% felt "somewhat or very dissatisfied." A majority (53%) reported that that they liked their living situation better after they had adjusted to the change in environment. According to the respondents, the average number of weeks they took to adjust to their foster families were 3.3 with a range of 1 to 8 weeks. Only one respondent reported that he had not adjusted at all.

Participants were asked what they liked best about foster family care. Answers most frequently given were: 1) getting good care in an atmosphere of independence, 2) companionship, and 3) feeling happier than they would be in a nursing home. Respondents reported that they disliked the following aspects of foster care: 1) lack of mobility; 2) feeling of isolation especially when living far from their hometowns; 3) preference for living alone rather than with a family; 4) dislike of sharing the bathroom or the telephone; and 5) fear of burdening foster families.

G. Functional Abilities and Interpersonal Skills (Tables 4 and 5)

The foster family caretakers were asked to rate the participants on their functional abilities and interpersonal skills. Areas where participants "sometimes or usually" needed assistance were bathing or showering (74%), leaving the house (61%), and walking (52%). In addition, about two-fifths (39%) sometimes or usually needed assistance with dressing and 13% were reported to require assistance with eating. About one-fourth (26%) had difficulties controlling bowel and bladder functions.

With regard to interpersonal skills, caretakers reported that half of the participants "sometimes or usually" had a problem in the following areas: 1) overall mental outlook (55%), 2) following health instructions (48%), 3) communication (39%), 4) cooperation (37%), and 5) mental alertness (34%).

3. Description and Responses of Family Caretakers

A. Demographic Characteristics of Family Caretakers (Table 3)

In many respects, the demographic characteristics of the primary family caretakers were similar to those of the participants, i.e., the average caretaker was a white female, Catholic, with a high school education or less. The caretakers were younger than the participants, with an average age of 49 and an age range of 28-75 years.

The overwhelming majority were women (94%), half (50%) of whom were married, with 47% widowed, divorced or separated. None of the caretakers were in the "never married" category. While 95% of the participants were white, only 82% of the caretakers were white, with 12% Black and 3% Hispanic. The caretakers had slightly less formal education than the participants, with only 9% completing college. However, 16% had received some training related to their current work as foster caretakers, including RN training and home health and nurses aide experience.

The overwhelming majoring of caretakers (91%) owned the houses they lived in, while 6% rented houses and just 3% lived in rented apartments.

B. Financial Status/Employment

Nearly half (47%) of the caretakers responding to the questionnaire reported that they had worked outside of their homes during the past 5 years. For those who had worked, the average number of years working was 4. Caretakers reported working in a variety of blue collar and clerical jobs, with over one-third (37%) working as nurses aides, home health aides or RNs. The average gross wage received by those who had worked was $150 per week.

The average income in the caretakers' households ranged from $293 per month to $1500 per month with a mean of $899 per month. The caretaker reported herself as the primary wage earner in nearly half of the cases (47%) while the husband was reported as primary wage earner in 38% of the cases. In 44% of the caretaker households, a third resident contributed to the household income, usually an adult child or a boarder.

C. Adult Foster Care Experience

Caretakers most often heard about the foster family care program through the following sources: 1) newspaper publicity (47%), 2) friends or relatives (20%), 3) television (15%), 4) radio (9%), 5) contact with sponsor agency (6%), and 6) flyers, (3%).

Length of time respondents had participated in the program ranged from 1 to 15 months with a mean of 7 months. Most of the respondents had cared for only one participant while 13% had cared for two participants and 1 had cared for 3 participants since the program had begun. In cases where participants had left foster care, reasons for termination had included the following: 1) participant had to be hospitalized, 2) participant placed in nursing home because of incontinence, and 3) participant disrupted the household during the night.

Over half of the responding caretakers (53%) reported that they provided 76-100% of the care to the participant living in their homes while 26% reported providing 51-75% of the total care with other family members assisting them.

D. Previous Experience with Foster Care

Only 12% of the responding caretakers had participated in other foster care programs, including: the Veterans Administration; Mass. Department of Mental Health; and the Mass. Department of Public Welfare Foster Child Care Program.

E. Activities of Foster Family Care

In most of the foster families (88%) the participant ate at least one meal a day with the family, while the rest of the families reported that family meals occurred at least once a week. In three-quarters (76%) of the households the participant shared a bathroom with other household members, usually with just one other person.

Just over one-third (39%) of the participants required nighttime assistance at least once a month, 15% required assistance at least once every night and another 6% needed help at least once a week.

Half of the participants (50%) regularly joined the foster family on social occasions such as holidays, birthdays, day trips and parties. Only 6% of the participants "hardly ever or never" participated in special family activities, according to the caretakers.

F. Respite Care Arrangements

Very few caretakers reported that the foster family had been away overnight and that respite care arrangements had been needed. However, caretakers reported that they would make the following arrangements should the need for overnight respite care arise: 1) ask a friend, relative or neighbor to stay with the participant: or 2) hire a sitter or a nurse. Arrangements for daytime respite included relatives, friends, neighbors and home health aides.

The participant had gone away overnight with the foster family in only one case.

In 38% of the families, the adult participant had gone away for at least one night without the foster family, usually to visit a relative or to go to the hospital.

G. Support from Sponsor Agency

Nearly all (97%) of the caretakers reported that they had received adequate support and training from the sponsor agencies. More than half (59%) of the respondents saw an agency worker at least once a week while the rest reported seeing the worker at least once a month.

H. Satisfaction with Foster Family Care Program (Table 6)

The largest majority (79%) of the foster caretakers reported that they were "satisfied or usually satisfied" with the foster family care program. Aspects of the program they liked best were: 1) the opportunity to help others; 2) the companionship; and 3) the financial support.

Aspects of the program they reported liking least were: 1) inadequacy of financial remuneration; 2) lack of respite care and feeling of confinement; 3) lack of privacy; and 4) difficulty of dealing with incontinence and sleeplessness. Changes the caretakers would like to see made in the program were: 1) more background information on participants; 2) more participant involvement in activities outside of the house; and 3) more transportation available to participant.

C. Cost Study

The objective of the cost study is to determine the costs of the Medicaid Foster Family Care Program to the Department of Public Welfare and to compare the costs with those of other long-term care services and adult foster care programs. This evaluation component includes the following sections: 1) an assessment of the projected administrative and program costs per participant per diem; 2) a comparison of projected foster family care rates with rates of other Medicaid funded long-term care services and with other adult foster care programs; 3) an assessment of additional health maintenance costs per participant; and 4) an assessment of the average SSI costs per participant.

1. Overview

Overall, the projected costs of the Medicaid Foster Family Care Pilot project, while reflecting the growing costs of long-term care services, appear to be competitive with alternative types of care provided within institutions as well as in the community. A projected per diem rate of $17.80 places foster family care costs lower than Level III ICF costs and slightly higher than Level IV rest home costs, which is appropriate given the level of care provided.* Similarly, considering the extent of partici-

*Actual costs of the Foster Family Care Pilot Project were not computed for purposes of this report. During the first year of operation, sponsor agencies put most of their efforts into the development of back-up services, linkages with other agencies, training packages, outreach, and other program components which they were required to develop prior to client placement as part of their contract with the Department of Public Welfare. An actual computation of administrative costs during the first year would have resulted in very high and unrealistic total program costs which would not reflect actual costs for a foster family care program operating at capacity. A lengthy start-up period for the development of alternative community-based care programs is expected. The Medicaid Adult Day Health Program experienced a similarly slow start-up period.

Therefore, a projected per diem rate of $17.80 which is based on the assumption that a sponsor agency has 20 clients in placement, was used as a basis of comparison for purposes of this evaluation. The $17.80 projected rate was suggested in a memo written by Richard Hill, consultant to the Commissioner of the Rate Setting Commission in October, 1979. The projected rate is not intended to be an actual rate, but is an estimated program rate which can be useful in comparing foster family care with rates for other programs. Because a projected rate is used, cost comparisons presented in this report should be interpreted cautiously. At this time, a fully creditable and statistically reliable comparison of rates is not available.

The $17.80 projected rate includes the following components: 1) an estimated administrative rate of $4.80 per client per day, assuming that 20 clients are in placement in each sponsor agency; 2) a maximum per diem payment to the foster family of $13.00 which is the current rate paid. The portion of the $13.00 paid by Medicaid is reduced by the clients' SSI contribution which is estimated to average $5.61 per diem. The total projected program cost, then, is $17.80 ($13.00 plus $4.80).

pant care required in the foster family care program and the stringent regulations requiring a maximum of 2 participants per family, the projected per diem rate of foster family is competitive with rates of other adult foster care programs. The $17.80 projected rate falls well below the per diem rate paid by the Department of Mental Health ($29.58-$49.08) for specialized foster care.

While additional health maintenance costs appear to be high, $3704.48 per client per year, the figures included in this study are based on a limited sample and may not be reflective of overall health maintenance costs for foster care participants. In addition, comparisons with health maintenance costs, Level III populations, and community-based adults living with families may show that these costs are not unusual for the needs of the population being served.

2. Assessment of Per Diem Costs

The development of the Foster Family Care Program was a joint endeavor by the Department of Elder Affairs and the Department of Public Welfare during the first year. DEA funded administrative costs until December 31, 1979. Effective January 1, 1980 the DPW assumed responsibility for administrative costs as well as program costs for each Medicaid recipient in placement.

Costs fluctuated during the start-up year, with the monthly rate to foster families increasing from $300 per month to $403 permonth which included reimbursement for room, board and personal care services. The participant received an additional $78.00 per month for a personal needs allowance. If the Medicaid eligible participants' monthly income, minus the monthly personal needs amount ($78.00) was less than $403, then Medicaid was billed for the difference.

For purposes of this evaluation, the following projected per diem rates will be used as the basis of comparison. These rates have been proposed by the DPW as reflecting the projected operating costs of foster family care assuming that sponsor agencies are operating at capacity.

Assuming a caseload of twenty clients per placement agency, the Department estimates a per diem, per client administrative expense of $4.80, in addition to the current per diem payment to the foster family of $13.00. This amount is reduced by the clients' SSI contribution which is expected, on average, to be $5.61 per diem. Accordingly, the total projected program cost inclusive of the (SSI/SSA) patient paid amount is $17.80 per client per day.*

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*Hill, Richard, "Contrasting Adult Foster Care with Other Models of Service Delivery," October 1, 1979 (Memorandum to the Commissioner of the Rate Setting Commission).

3. Comparison of Program Per Diem Rates with Other Medicaid Services and Other Adult Foster Care Programs

The $17.80 projected per diem rate for foster family care services falls between the costs of Level III Intermediate Care Facility per diem rates ($23.00-$30.00) and Level IV Rest Home rates ($15.00).

The projected rate is slightly higher than the per diem rate estimated for Case Managed Community Placement ($17.09).* The following chart compares the cost of foster family care with other long-term care services.

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*Ibid.

Chart I

Comparison of Per Diem Rates for Selected Long-Term Care Services

	Program	Funding Source	Per Diem Rate*
1.	Level III ICF		
	A. single level facility	Title XIX	$30.00
	B. multi-level facility	Title XIX	$23.00
2.	Medicaid Foster Family Care	Title XIX	$17.80 (projected rate)
3.	Level IV Rest Home	SSI	$15.00
4.	Case Managed Community Placement**	Title XIX	$17.09
5.	Adult Day Health Care	Title XIX	$16.00

Source: Hill, Richard, "Contrasting Adult Foster Care With Other Models of Service Delivery," October 1, 1979 (Memorandum to the Commissioner of the Rate Setting Commission).

Accurate comparisons between the cost of the Foster Family Care Program and other adult foster care programs are not possible because other programs providing "personal care" services for disabled adults do not exist. Other differences occurring among foster care programs include stringency of program regulations, number of placements allowed per home, and level of supervision provided to foster family caretakers. Unlike the Department of Mental Health and Veterans Administration programs in foster care, the Medicaid foster family care program agreement allows only 2 participants to be placed in any family home. Given these differences, the following chart provides estimates of per diem rates for 5 foster care programs.

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*These rates are estimates based on prevailing per diem rates charged for the various services, including program as well as administrative components.

**The long-term care case management project is jointly funded by the Department of Elder Affairs and the Department of Public Welfare's Division of Medical Assistance. The program monitors cost of community placement for individuals who have applied for nursing home care and who are living at home with their own families. Non-institutional support services such as homemakers, VNA and private duty nurse services are included in the cost estimate.

Chart II

Comparison of Per Diem Rates for Selected Foster Care Services

	Program	Administrative Agency	Per Diem Rate *
1.	Specialized Home Care	DMH	$29.58-$49.08
2.	Medicaid Foster Family Care	DPW (Title XIX)	$17.80 (projected rate)
3.	Veterans Administration Foster Care	Veterans Administration	$10.83 **
4.	Specialized Foster Care	DPW/Department of Youth Services	$10.00-$20.00
5.	Childrens Foster Care	DPW	$7.35 - $8.78 ***

Source: Hill, Richard, "Contrasting Adult Foster Care With Other Models of Service Delivery," October 1, 1979 (Memorandum to the Commissioner of the Rate Setting Commission).

4. Additional Health Maintenance and Services Costs

An assessment of foster family care costs is not complete without including the costs of health maintenance services provided by Medicaid to each participant during foster care placement. While the scope of this evaluation does not permit comparison of health maintenance costs with those provided in Level III care, the following summary of health maintenance costs provides a useful supplement to the total cost assessment of foster family care. Because of the small population of participants included in this assessment (n = 44), the figures presented in Chart III should be interpreted with caution.

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*These rates include administrative as well as program costs except where noted.

**Does not include costs of recruitment or placement; the VA places up to 16 patients per house.

***Does not include an administrative cost.

Chart III

Summary of Title XIX Health Maintenance Costs Per Participant *

Service	Estimated Cost Per Unit **	Average Units Per Client Per Year ***	Average Costs Per Client Per Year
Physician visits****	$16	6.54 visits	$104.64
Home Health Aide	$6.50/hr	7.02 visits	$ 45.63
VNA/RN visit	$18.00/visit	2.79 visits	$ 50.22
Physical Therapy	$10.00/visit	3.27 visits	$ 32.70
Transportation (round trip)			
- taxi	$10.00/ride	14.59 rides	$145.90
- ambulance	$84.00	1.43 rides	$120.12
- chair car	$30.00	.14 rides	$ 4.20
Occupational Therapy	$10.00	.82 visits	$ 8.20
Speech Therapy	$14.00/visit	7.63 visits	$106.82
Level II Nursing Home Care	$35.00	7.57 days	$264.95
Acute Hospital Days	$260.00	10.84 days	$2818.40
Dental Services	$10.00	.27 days	$ 2.70
TOTALS			$3.704.48

* All services reported were provided through Title XIX except physician visits which were funded by Titles XIX and XVIII.

** Estimated rates per unit reflect estimates of average costs of services based on the Medicaid Policy Manual.

*** Average costs per client per year were calculated using weighted averages, based on 44 participants with a mean length of stay in foster care of 4 months. Utilization rates were computed and annualized.

**** Rate based on 30 minute office visit excluding laboratory or other fees.

5. Assessment of Average SSI Costs Per Participant

Participants' SSI income ranged from $2.02 to $337.00 with a mean of $153.92. In computing the proposed per diem rate for foster family care, the Department assumes that an average of $5.61 per diem will be paid from the participants' SSI check toward the total fee for foster family care.

IV. CONCLUSIONS AND RECOMMENDATIONS

A. Conclusions

The results of the evaluation of the Foster Family Care Pilot Project indicate that foster care can be an effective alternative to institutionalization for disabled adults. The Massachusetts General Hospital Foster Family Care Project provides a clear picture of a functioning foster family care agency which is in full operation and which provides excellent support services to participants and family caretakers. Although participant placement rates were very low for the project as a whole, the success of the Massachusetts General Hospital program suggests that foster family care is a positive cost effective program for preventing the institutionalization of certain disabled adults.*

The following are highlights of the program's strengths identified by the evaluation:

1. Overall, sponsor agencies complied with contractual obligations set forth by the Department of Public Welfare, thus assuring that adequate supervision and support mechanisms were developed before participants were placed in foster care.

2. Overall, both participants and foster families expressed satisfaction with the foster family care program. Participants generally found family care to be strongly preferable to nursing home placement while family caretakers found the task of caring for disabled participants to be manageable and satisfying. Caretakers were particularly resourceful in developing informal short-term respite arrangements.

3. Only in one program, the Massachusetts General Hospital's program, were the per diem costs competitive with other services and programs. This was so because the number of placements made by MGH were sufficient to reduce the per placement administrative costs to a level where costs were comparable with other long-term care services.

The following is a summary of major weaknesses identified in the evaluation:

1. The major weakness in the pilot program was the inability of most of the sponsor agencies to place adequate numbers of participants into foster family care within the 12 month start-up period. Reasons for the low placement rates included:

   a) Sponsor agency staff time was primarily devoted to developing program components and complying with Provider Agreements, leaving insufficient time for recruitment and placement;

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*Because of the long "start-up" time required for this program, placement rates made during the 12 month evaluation period were inappropriate for determining the success of adult foster family care. Therefore, the Massachusetts General Hospital program, which began early in 1978 and which benefited from private foundation support, provides the best indication of a successful foster care program.

b) The size and types of agencies selected for the foster family care program were inappropriate in some cases;

c) Geographic boundaries between programs were sometimes too close together, thus limiting the extent of potential foster family and participant pools for recruitment;

d) The program introduced a new concept which took time for the general public to become familiar with and accept;

e) Reimbursement rates to foster families were initially inadequate.

2. The "lag time" required for Medicaid billing sometimes put a strain on sponsor agency budgets.

B. Recommendations

The following recommendations address the program weaknesses cited above and are intended to assure that the foster family care program continues, providing high quality, cost effective care to program participants and family caretakers.

1. The Department of Public Welfare should continue to fund only those sponsor agencies which can build their participant census to a minimum of 20 within 18 months of operation.

2. The Department should develop a RFP process for attracting and selecting new sponsor agencies. Factors to consider in the selection of sponsor agencies include:

   a) demonstrated capability of the proposed sponsor to provide or arrange for the provision of medical back-up and to administer a successful foster family care program;

   b) demonstrated ability to attract supplemental funding and to coordinate ancillary services for the program;

   c) diversity of geographic location so that all regions of the state, including major urban centers, are served by sponsor agencies; and

   d) expanded criteria for sponsor agencies to include proprietary agencies such as nursing homes on a trial basis.

3. Discussion with the Department of Public Health regarding the interpretation of the statute as it applies to this program should continue so that the maximum number of participants residing in one home can be expanded from 2 to 3 in exceptional circumstances.

4. Systematic, ongoing training should be developed by the Department for family caretakers using Title XX training modeled after the Foster Parent Training Program.

5. Each sponsor agency should develop several short-term respite care homes in each geographic area to provide ongoing respite as well as emergency back-up to foster family care.

6. The development of a uniform participant assessment tool should be continued by the DPW Medical Division to assure statewide consistency in the level of disability of participants placed into foster care.

7. Additional health maintenance services, such as adult day health and occupational and physical therapy services, should be carefully monitored and limited for foster family care participants.

TABLES

Table 1

Summary Table of the Numbers of Clients and Families Served

Total Clients Served During the Year

Total Clients Referred	732	(100%)
Total Clients Interviewed	216	(30%)
Total Clients Eligible	123	(17%)
Total Clients Placed with Families	48	(7%)

Total Foster Families Served During the Year

Total Families Identified	341	(100%)
Total Families Interviewed	134	(39%)
Total Families Eligible	69	(20%)
Total Families in the Program	35	(10%)

Table 2

Sources of Referrals of Participants Screened by Sponsor Agency

Referral Source	Number of Referrals	Percentage
Hospital	309	53%
Family/Friend	83	14%
Home Care Corporation	46	8%
Nursing Home Level II	34	6%
Private Social Service Agency	29	5%
Self	26	4%
VNA	18	3%
VA	11	2%
Physician	8	1%
Council on Aging	8	1%
Other Foster Care Projects	6	1%
Mental Health Clinic	7	1%
	585*	99%

*Missing data: 147 cases

Table 3

Socio-Demographic Characteristics of Participants and Caretakers

			Missing Data	Total
AGE	Range	Mean		
Participant	32 to 93 years	65 years	0 (0)	100% (38)
Caretaker	28 to 75 years	49 years	0 (0)	100% (34)
SEX	Male	Female		
Participant	21% (8)	79 (30)	0 (0)	100% (38)
Caretaker	6% (2)	94 (32)	0 (0)	100% (34)

MARITAL STATUS	Married	Widowed	Divorced	Separated	Married		
Participant	3% (1)	42 (16)	16 (6)	0 (0)	39 (15)	0 (0)	100% (38)
Caretaker	50% (17)	38 (13)	3 (1)	6 (2)	0 (0)	3 (1)	100% (34)

RELIGION	Catholic	Protestant	No Organized Religion		
Participant	61% (23)	34 (13)	3 (1)	3 (1)	100% (38)
Caretaker	65% (22)	32 (11)	0 (0)	3 (1)	100% (34)

RACE	White	Black	Hispanic or Portuguese		
Participant	95% (36)	5 (2)	0 (0)	0 (0)	100% (38)
Caretaker	82% (28)	12 (4)	3 (1)	3 (1)	100% (34)

EDUCATION	Less than High School	High School Graduate Technical Training	College Graduate and Post Training		
Participant	47% (18)	50 (19)	3 (1)	0 (0)	100% (38)
Caretaker	41% (14)	44 (15)	9 (3)	6 (2)	100% (34)

Table 4

Extent of Caretaker Assistance With Activities of Daily Living

Activity	Usually Does Not Need Assistance	Sometimes Needs Assistance	Usually Needs Assistance	Missing Data	Total
Bathing or showering	24% (9)	21 (8)	53 (20)	3 (1)	99% (38)
Dressing	47% (18)	26 (10)	13 (5)	13 (5)	99% (38)
Using Toilet	66% (25)	8 (3)	3 (1)	24 (9)	101% (38)
Transferring from bed to chair	61% (23)	5 (2)	3 (1)	31 (12)	100% (38)
Eating	63% (24)	10 (4)	3 (1)	24 (9)	100% (38)
Walking	45% (17)	34 (13)	18 (7)	3 (1)	100% (38)
Leaving the house	29% (11)	16 (6)	45 (17)	10 (4)	100% (38)

Table 5

Participants' Interpersonal Skills

Area	Not A Problem	Sometimes A Problem	Usually A Problem	Missing Data	Total
Overall Mental outlook	39% (15)	42 (16)	13 (5)	5 (2)	99% (38)
Health Alertness	55% (21)	29 (11)	5 (2)	11 (4)	100% (38)
Communication	58% (22)	26 (10)	13 (5)	3 (1)	100% (38)
Cooperation	58% (22)	26 (10)	11 (4)	5 (2)	100% (38)
Ability to follow health instructions	42% (16)	37 (14)	11 (4)	11 (4)	101% (38)

Table 6

Overall Feeling About the Foster Care Relationship

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied	Total
Participant	58% (22)	31 (12)	3 (1)	3 (1)	5 (2)	100% (38)
Caretaker	79% (27)	12 (4)	3 (1)	3 (1)	3 (1)	100% (34)

APPENDICES

For Month of _____, 1979

To : Department of Elder Affairs

FROM:

PREPARED BY:

Telephone number of person preparing the report: _____

1A. Total number of clients served this month: _____

2 Client Characteristics - New Clients

A

_____ =

Total # New Clients Served This Month

= B (1) American Indian + (2) Asian + (3) Black, not of Hispanic Origin + (4) Hispanic + (5) White, not of Hispanic Origin

= C (1) Low Income (2) Other (3) Unknown

= D (1) Under 60 + (2) 60 - 64 + (3) 65 - 69 + (4) 70 - 74 + (5) 75 - 79 + (6) 80 - 84 + (7) 85+

= E (1) Male + (2) Female

= F (1) Living Alone + (2) Spouse Only + (3) Spouse and Children Only + (4) Children Only + (5) Other Combination + (6) Unknown

= G (1) Mobility Impaired + (2) Communication Impaired + (3) No Handicap

3. Clients Served/Service Category/Units of Service

A	B		C	
	# Clients Served		# Units of Service	
Service Category	(1) Planned	(2) Actual	(1) Planned	(2) Actual
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

4. Summary

A. Total number of clients served this month: _____

B. Total number of <u>new</u> clients served this month: _____

C. Total number of clients terminated this month: _____

D. Total number of clients served to date by the project: _____

5A. Referral Information:

List agencies/organizations <u>from which</u> new clients were referred during the report period, and the number of referrals <u>from each</u>:

Name	#	Name	#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. List agencies/organizations <u>to which</u> clients were referred during the report period and number of referrals to each:

Name	#	Name	#
_____	_____	_____	_____
_____	_____	_____	_____

6. Service Characteristics:

(Service Characteristics will vary from project to project, and will be designed individually.)

7. Program Performance: (Please respond Yes or No; if no, give reason.)

A. Is the work program proceeding as planned? Yes ( ) No ( )

B. Are the original objectives, as outlined in the proposal, realistic? Yes ( ) No ( )

8. Comments: (List any unanticipated problems that are occurring; requests for technical assistance, etc.)

For Department of Elder Affairs use:

Date Received: _____

Reviewed By: _____

Action Required: _____

_____

6. Service Characteristics

I. Active Client Service Characteristics

(1) Client Code #	(2) Type Of Care	(3) Service	(4) Provider	(5) Public Funding	(6) Total # Units/Mo.

II. Terminated Client Service Characteristics

(1) Client Code #	(2) Total Time (in-home)	(3) Reason for Termination	(4) New Residence

III. Service Characteristics of Adults Referred to Project

A. Referrals

(1) Referral Source	(2) # Referred	(3) # Interviewed	(4) # Ineligible	(5) # Eligible

B. Reasons for Ineligibility (aggregate by # Ineligible)

(1) # Ineligible	(2) Primary Reason for Ineligibility

IV. Foster Family Service Characteristics

A. Eligible Families

# Identified	# Interviewed	# Eligible

B. Ineligible Families

# Ineligible	Reasons for Ineligibility

V. Year-to-Date Information Summary

A. Clients

1. _____ Total # Referred.
2. _____ Total # Interviewed.
3. _____ Total # Eligible.
4. _____ Total # Placed with Foster Family.

B. Foster Families

1. _____ Total # Identified.
2. _____ Total # Interviewed.
3. _____ Total # Eligible.
4. _____ Total # Ineligible.
5. _____ Total # With Clients
6. _____ Total # Foster Families Available for Emergency Care.

Sponsoring Agency_____

On-Going Quarterly Administrative Reporting Form

Please fill out this form based on the preceeding three months' activities. This is a quarterly form which should be returned by the following dates: August 1, November 1, 1979 and February 1, 1980. Return to: Arleen Silverlieb, Medical Division, Department of Public Welfare, 600 Washington Street, Boston, MA 02111.

Inter-Agency Agreements and Decisions

1. With which acute care facilities have you signed transfer agreements in the last three months?_____

_____

_____

2. With which acute care facilities do you still expect to sign transfer agreements?_____

_____

_____

3. Have procedures for discharge planning been developed?

_____(1) Yes, a copy of the plan has been sent to D.P.W.

_____(2) Yes, a copy of the plan is attached.

_____(3) No, the plan has not yet been developed.

4. Have you made additional arrangements to provide emergency and respite care in the past 3 months?

_____(1) Yes, (please specify):_____

_____(2) No

5a. What arrangements have you used for emergency and respite care in the past three months?_____

_____

b. Were these arrangements adequate? ____Yes ____No

c. If no, please explain:_____

_____

_____

6. With which VNA's have you made formal agreements in the past three months?_____

_____

7. In what specific ways have you utilized VNA services in the past 3 months?_____

_____

8. Please list the other agencies and organizations which have provided services to participants in the last 3 months. (Example: trasnportation, adult day health, counseling)

	Name of Agency/Organization	Type of Service
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

9a. During the last 3 months, have you ascertained from the local welfare service office each participants' recurring monthly income? ____Yes ____No.

b. If no, please explain:_____

_____

_____

10a. During the last three months, have you notified the local welfare service office within one working day each time a participant was admitted to a nursing home? ____Yes ____No.

b. If no, please explain:_____

_____

_____

Outreach to Families and Participants

11. What specific outreach activities have been conducted to reach potential participants in the past three months?____

_____

_____

12. What specific outreach activities have been conducted to reach potential families in the past three months?_____

_____

_____

Family Orientation

13a. How many families have you oriented in the past three months?

_____

b. Have there been any substantial changes or additions to your family orientation program in the last three months?

____ Yes ____No

c. If yes, please specify and attach any new training materials:

_____

_____

_____

Foster Family and Participant Supervision

14. Generally, have the required visits to the foster family and participants been made:

A. three days after placement?___(1)Yes ___(2)No

B. weekly during the three months?___(1)Yes ___(2)No

C. ongoing monthly after the three months?___(1)Yes ____(2)No

Please specify any obstacles you may have encountered in fulfilling the required number of visits._____

_____

_____

15a. Do the number of visits seem appropriate?

____(1) Yes ____(2) No

b. If no, please explain:_____

_____

_____

16a. Has emergency telephone service been available to families and participants continuously during the past 3 months?

____(1) Yes ____(2) No

b. If no, please explain:_____

_____

_____

c. How many calls were received after normal operating hours in the past three months?_____

d. Have you had difficulty with the arrangements of 24-hour telephone service?____Yes _____No

e. If yes, please explain:_____

_____

_____

17a. Has your agency secured appropriate medical approval for each participant who has entered foster care in the past three months?

_____Yes ____No

b. If no, for how many participants have you not secured medical approval?_____

c. Please explain:_____

_____

_____

18a. Has your agency obtained periodic health status reports from each participants' health care provider during the last three months? _____Yes ____No

b. If no, for how many participants have you not obtained periodic health status reports? _____

18c. Please explain:_____

_____

_____

19a. Has each participant who has entered foster care in the past three months signed a "release from responsibility" agreement?

____Yes ____No

b. If no, how many participants have not signed the release?

_____

c. Please explain:_____

_____

_____

20a. Are all of the staff positions specified in your grant proposal filled at this time? _____(1) Yes _____(2) No

b. If no, please fill in the following information:

TITLE OF VACANT POSITION	REASON FOR VACANCY	DATE EXPECTING TO FILL POSITION
1.		
2.		
3.		

21. What efforts have you made in the past three months to secure funding for the program from funds other than DEA or Medicaid?

_____

_____

_____

22. What steps have been taken to implement the internal evaluation in the past three months?_____

_____

_____

_____

_____